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THE HOSPITAL: A CHANGING PERSPECTIVE*

Chairman's Opening Statement

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THE hospital—as an institution—stands today at the very center of the delivery system of medical care. It would be well to recall that this has not always been the case. As Dr. S. S. Goldwater, distinguished hospital administrator, has pointed out, there was something about hospitals that made men shun them. Goldwater recalled that in the 16th century Sir Thomas More, in designing his ideal community, looked forward to a hospital system in which

> . . . hospitals are furnished and stored with all things that are convenient for the ease and recovery of the sick—and those that are put in them are looked after with such tender and watchful

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> care and are so constantly attended by their skillful physicians that . . . there is scarce one in the whole town—that if he should fall ill—would not chose to go thither than to lie sick at home.

Even in the 19th century the establishment of a hospital in such countries as England and France was an event fraught with evil as well as good. As Florence Nightingale pointed out, "it may seem a strange principle to enumerate as the very first requirement in a hospital *that it should do the sick no harm.*"

Throughout history the pattern of medical care has been differentiated on the basis of social circumstances. Not too many years ago the poor were taken care of in hospitals, the middle-income group sought care at home or in the home of the family doctor, and the wealthy were treated at home or in the consulting rooms of specialists. The care of the indigent sick in the 19th century in the famous hospitals of Europe was very well described by Pedro Lain Entralgo in his book *Doctor and Patient:*

> The patient usually arrived at the hospital in a state of mind combining confidence and resignation;—he knew that—as part of his "poor man's treatment,"—he would receive an excellent diagnosis because the hospital doctors were usually the best in the country; treatment, though necessarily limited by the never-abundant economic resources of the hospital; and finally a careful autopsy, if he should die.

As the poor patients of Vienna used to say ironically in about 1850: "Viennese patients are lucky enough to receive an excellent diagnosis from Skoda and an excellent autopsy from Rokitansky." Today, with the hospital at the center of medical care, it is the facility to which the entire community—including the poor, the middle-income group, and the very wealthy—turns, not only for skilled diagnosis and treatment of the acute illnesses and other medical emergencies but also with the prospect of leaving the hospital improved if not fully recovered. The issue is thus no longer whether hospitals are essential but rather where they should be located, how they should be organized; what services they shall provide; and how these services shall be financed.

Five years ago—here at the Academy's Annual Health Conference—Professor Thomas McKeown of the University of Birmingham suggested that, in the future, hospitals should be transferred to well-chosen common sites in which *all* services—obstetrics, pediatrics, mental illness,

chronic illness, and *all* forms of acute care–should be centered. In an impressive paper he recommended that financial arrangements be such that hospitals should deal not only with short term illness but that there be general coordination at this center and common site–for all types of health services.

Not only is there a *problem* in the coordination–within the hospital–of long-term care, services for mental illness and ambulatory care, but there are difficulties arising out of the multipurpose nature of the hospital as an institution for teaching, research, and service. As hospital services become increasingly effective, the community at large presses for expansion of the services to meet a wide variety of needs. A hospital, as a complex organization, represents many constituencies and interests. The desire to serve its teaching responsibilities and research objectives, and to meet the requirements of constituencies which are interested in personal comprehensive care, often come in conflict with one another.

In order to focus on some of the important questions relating to the new role of the hospital as a community facility, this conference seeks to address itself to issues which–in the judgment of the Academy's Committee on Medicine in Society–are among the most perplexing. It is not our intention to attempt to cover the entire range of problems facing the hospital. In previous years we have dealt in greater detail with matters of health care, financing, ambulatory care, and health planning.

The title of the first panel reflects our committee's deep concern with the ways in which the hospital can become more effective in the delivery of ambulatory care and mental-illness services and in meeting the needs of long-term patients. We are also interested in the impact on hospital services. Even with new patterns of financing health care–which might be brought into being by the adoption of national health insurance programs–difficult problems would still remain in setting priorities, in developing an effective array of health services, and in introducing new incentives for more economical management of the hospital.

In the second panel, we shall direct ourselves to some of the problems in the internal administrative organization of hospitals which have been particularly troubling to some health professionals and some hospital administrators. In some hospitals, severe strains have been developing in relations among the full-time staff, the attending staff, and the residents and interns in training. The debate revolves around such questions as: What is the respective responsibility and authority of the

various groups in the care of patients? How does one balance the adequacy of the training experience for the resident and intern with the needs of the patient? What ethical problems arise in disclosing to the patient details of the medical management of his case, including the involvement—if any—of the patient with research and training functions? How does one develop the proper allocation of research, training, and service functions in the university hospital and in the community hospital? What are the proper financial and organizational relations for the medical staff? What role should other members of the health care team play in decision making about the care of patients? What has been the impact on hospitals of pressure by groups of medical students, interns, and residents who wish to change the emphasis of hospital programs?

In the third panel we shall discuss relations between different hospitals and between the hospital and the community. McKeown's model for integrating on a single site a hospital center combining various services, i.e., *chronic* illness, *acute* illness, and *mental* illness, is only one possible pattern. We find patterns of relations developing in a much more complex manner than that proposed by McKeown. There are new moves toward regionalization, toward merger of hospitals and toward hospital networks: What should be the respective function and organization of public and private hospitals? Are there any particular patterns of regionalization and hospital networks that will provide the model for reorganizing the hospital system? What future is there for hospital chains organized on a profit-making basis? The profit-making hospital is moving into the health care field; whether this is merely a response to a market demand for stock issues or whether this forecasts a basic change in the hospital system remains to be seen.

In the fourth panel we shall discuss the question of a single standard of care for all patients. Pedro Lain Entralgo, whom I have cited earlier, suggests that the crisis in medical care has been in existence since the latter part of the 19th century. To him it represents a crisis in the relation between doctors and patients. The important aspect of this crisis is that

> . . . the traditional distinction between medicine for the rich and medicine for the poor could no longer be tolerated especially when at the end of the 19th Century and the beginning of the 20th, therapeutic measures (such as drugs, surgery, etc.) became

> strikingly effective and notoriously expensive at the same time. Nor was this all. Besides receiving normal hospital treatment, patients had to lend their living bodies for clinical teaching purposes, and their corpses for the teaching of anatomy. As soon as a poor man fell ill, his body became res publica . . . whereas the rich man's body was allowed inviolable privacy.

This crisis in medical care is at the heart of the controversies ranging about the issue of a single standard of care, for both clinical and social reasons. In moving in the direction of a single standard of care, the question is "How far are we required to go?" If it is argued, for example, that we should not have a separate municipal system that cares for the poor, how shall this be achieved? How are unreasonable distinctions based on economic status to be eliminated? What distinctions are permitted in medical care other than the usual ones based on illness? Are separate facilities equal? What are the problems in obtaining the resources that we need to move toward a single standard of care? Does the thrust for community participation move us closer to the development of a single standard of care? What are the appropriate arrangements for such broadened lay participation?

We raise these questions only to suggest some directions for the conference. It is our hope—as is customary at our annual health conferences of the Academy of Medicine—that we are providing a forum where we can have the frankest possible exchange of ideas on issues of relevance to all of us concerned with health. In this way we hope that we can *all* contribute to the clarification and resolution of the important issues now confronting the people in this field.